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# ABNORMAL AFFECT DUE TO TRAUMA

A traumatic event is a disastrous or an extremely painful event that has severe psychological and physiological effects. Traumatizing events include such personal tragedies as being involved in a serious accident, being the victim of violence, or experiencing a life threatening event. At the other end of the spectrum are life-threatening events that affect large numbers of people, such as fires, earthquakes, riots and war.

Abnormal affect due to trauma relates to the major psychological or emotional effect a serious traumatic event has on a person. We are usually prepared for many of the losses or at least we know ways to soften the blow. Once in a while, however, human condition intrudes something awful, something beyond routine setback occurs.

## POST TRAUMATIC STRESS DISORDER

*For the past 25 years, Malikan has suffered from flashbacks, in which he relives the horrors of his 9 months of active duty in Afghanistan. These flashbacks occur unexpectedly in the middle of the day, and Malikan is thrown back into the emotional reality of his war experiences. These flashbacks and the nightmares he often suffers from have become a constant source of torment. Malikan has found that alcohol provides the only escape from these visions and from the distress he feels. Often, Malikan ruminates about how he should have done more to prevent the deaths of his fellow soldiers, and he feels that his friends, rather than he, should have survived.*

Some people develop an acute stress disorder soon after a traumatic event. In this condition, the individual develops intense fear, helplessness or horror. Dissociative symptoms may appear, such as feeling numb, unreal or detached and amnesia about the event may develop. These individuals continue to re-experience the event in images, thoughts, dreams and flashback episodes.

Despite the extreme nature of the symptoms of acute stress disorder, most people are able to return to relatively normal functioning within days or weeks. Others however, do not. They go on to develop post traumatic stress disorder (PTSD), a disorder that is appropriate when the symptoms persist for more than a month.

Devastating and long lasting are the effects of certain types of extraordinary loss; they have been given a name and a diagnostic category of their own, post-traumatic stress disorder (PTSD).



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The precipitant post traumatic stress disorder is unusual. There is debate about what kind of precipitant events should qualify for diagnosis of PTSD. At the most extreme, some claim that events must be catastrophic, beyond the usual range of human suffering; living through earthquake, watching one's children torture, being kidnapped, experiencing hand to hand combat.

In DSM-IV having experience, witness or being confront by an event or events that involve the threat of death, injury or threat to physical integrity of self or others. This would include rape, mugging. Watching a bloody accident or committing an atrocity.

The criteria for disorder are:

1. The person relives the trauma repeatedly, in dreams, in flashbacks and daydream
2. Acting or feeling as if the event was recurring.
3. The person becomes numb to the world and avoids stimuli (for example, thoughts, feelings, places, and people) that remind him of the trauma.
4. The person experiences symptoms of anxiety and arousal that were not present before the trauma, including trouble sleeping, over alertness, trouble concentrating, exaggerated startle and outburst of anger.
5. The person is unable to remember an important part of the traumatic event.
6. The person has less interest or participation in activities and feels detached (or dissociated) from others with significantly impairs his/her functioning.
7. The symptoms last from more than a month.

Under this definition even in our relatively insolated and comfortable culture the lifetime prevalence of PTSD is shocking 7.8% with women having twice as much as men (Kessler et al., 1995). During the first month after trauma the problem can not by definition be PTSD. So during that time the syndrome is called acute stress disorder.

About 100000 rapes are reported every year and possibly 7 times as many go unreported. A women's reaction to rape is a kind of post traumatic stress disorder that was originally called rape trauma syndrome (Burgess & Holmstrom, 1979).

The victim relives the rape time and again, in waking life and in dreams. Sleep disturbances sets in and she has trouble with both getting into sleep and suddenly awakening. Rape victims startle easily. Women who were suddenly awaken by rapist find that their wake each night at about the same time screaming from rape nightmares. Normal sexual activity is difficult to resume and a complete avoidance of sex sometimes develops.

Victims with the least fear and the fewest flashbacks in the week following the rape recover more quickly. The very distress or numb victims had a poor outcome. The violence of the assault and how life threatening it was perceived as being also predicted worst long term outcome.



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# EXPLANATION FOR POST TRAUMATIC STRESS DISORDER

## BIOLOGICAL MODEL:

The structure of the brain can change as a result of trauma. For example, researchers have noted that these changes in the hippocampus may result from hyper arousal of the amygdale, a limbic system structure that is responsible for emotional responses. There is evidence for increased sensitivity of noradrenergic receptors in patients with PTSD (Bremner et al., 1998)

Evidence suggests that people with first degree relatives with a history of depression have an increased vulnerability to developing PTSD in response to traumatic life events (APA 2000). Research on twins shows a possible diathesis for PTSD (True et al., 1993).

## PSYCHODYNAMIC MODEL:

Freud described the symptoms such as those in the disorder currently labeled PTSD as representing a flooding of the ego's defenses with uncontrollable anxiety originating from the intense and threatening experiences. The experiences themselves may be traumatic enough to cause this reaction, or they may trigger painful memories of earlier unresolved unconscious conflicts and may cause anxiety to overflow as a result of an inability to keep these memories repressed.

## COGNITIVE BEHAVIORAL THEORY:

Cognitive Behavioral theorists (Foa, 1989) have incorporated the concept of how people's beliefs about a traumatic event influence how they cope with it. Thoughts that are likely to have a detrimental effect and can ultimately lead to PTSD, include excessive self-blame for events that are beyond personal control, as well as guilt over the outcome of those events (Kuberry, 1994; Turner, 1993).

## SOCIO-CULTURAL FACTORS:

Lack of social support after the war, may contribute to the development of the disorder (Spar, 1983). Other factors include such as education, income level and social status, provide additional pieces to the puzzle of PTSD. In assessing the role of sociocultural factors in the determination of PTSD, investigators have been particularly interested in the ways that disadvantaged economic settings may set the stage for PTSD.



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# TREATMENT OF POST TRAUMATIC STRESS DISORDER

Therapists have tried both drug therapy and psychotherapy with victims of trauma. The psychotherapies seem more promising than medications. Two types of psychotherapy have been widely used to treat the disorder – exposure and disclosure.

## DRUG THERAPY

In the best controlled study, participants suffering from PTSD were given either antidepressants or placebo. After the patients were given antidepressants the number of nightmares and flashbacks decreased but did not drop into the normal range. Numbing, a sense of distance from loved ones and general anxiety were not relieved. Overall, antidepressants and anti-anxiety drugs produce some symptom relief for some patients, but drug treatment alone is never sufficient to relieve the patient's suffering in PTSD (Demartino, Mollica and Wilk, 1995; Marshall, Stein & Yehuda, 1996; Rothbaum & Thomas, 1996).

## EXPOSURE

Exposure therapy is an extinction or habituation procedure in which individuals are repeatedly exposed to the fear stimulus. It has been used to treat PTSD and perhaps the best documented of its successful treatments. In the exposure treatment of PTSD, victims relive the trauma in their imagination while overcoming the tendency to disassociate from the experience. They describe it aloud to the therapist, with emotion and in the present tense. This is repeated session after session. The reliving is tape recorded and the patient plays it back at home frequently as a homework assignment.

When the efficacy of exposure therapy is tested it is usually compared to a weightless control and to stress inoculation training (SIT). SIT teaches a variety of anxiety management skills, including muscle relaxation, thought smoking and cognitive reconstructing.

In the best control study of exposure treatment today Edna Foa and her colleagues treated 96 women who were victims of assault unusually rape (Foa et al, 1999).

## OPENING UP

It is deriving from James Pennebaker's important work on silence. Pennebacker's have found that rape victims who do not talk about the trauma later suffer worst physical health than those who confined in somebody.

Psychological treatment thus produces good relief but as yet no cures for PTSD, and future research in this domain is essential. Evidence indicates that exposure and disclosure are all useful in treating PTSD patients. More control outcome studies are needed to verify and extend these results.



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# DISSOCIATIVE AMNESIA

*In a daze, Ayesha entered the mental health crises center, tears streaming down her face. "I have no idea where I live or who I am! Will somebody please help me?" The crises team helped her search her purse but could find nothing other than a photograph of a blond-haired little girl. Ayesha appeared to be exhausted and was taken to a bed, where she promptly fell asleep. The crises team called the local police to find out if there was a report of a missing person. As it turned out, the little girl in the photograph was Ayesha's daughter. She had been hit by a car in the parking lot of a shopping center. Although badly injured with a broken leg, the child was resting comfortably in the pediatric ward of the hospital. Her mother, however, had disappeared. Ayesha had apparently been wandering around for several hours, leaving her wallet and other identifying papers with the hospital social worker in the emergency room. When Ayesha awoke, she was able to recall who she was and the circumstances of the accident, but she remembered nothing of what had happened since.*

In dissociative amnesia, formerly called psychogenic amnesia, the individual is unable to remember important personal details and experiences usually associated with traumatic or very stressful event. This memory loss is not attributable to brain dysfunction associated with brain damage or drugs, nor is it a matter of common forgetfulness. The information is not permanently lost but it cannot be retrieved during the episode of amnesia.

Most often the memory loss involves all events during a limited period of time following some traumatic experience, such as witnessing the death of a loved one. Dissociative amnesia is rare, yet it is the most common of the dissociative disorders. It received a great deal of attention following the two world wars, in which many individuals with combat-related trauma experienced amnesia (Kardiner & Spiegal, 1947).

There are four forms of amnesia, each associated with the nature of a person's memory loss.

1. Localized Amnesia – the most common form, the individual forgets all events that occurred during a specified time interval.
2. Selective Amnesia – the individual fails to recall some, but not all, details of events that have occurred during a given time period.
3. Generalized Amnesia – is a syndrome in which a person cannot remember anything at all from his/her life.
4. Continuous Amnesia – involves a failure to recall events from a particular date up to and including the present time.



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# DISSOCIATIVE FUGUE

*Faraha was as administrator at a small college in a rural town. She was a reliable worker, keeping mostly to herself and rarely discussing her personal life with her colleagues. All they knew about her was that he lived with her husband, Shabbir, and their two teenage children. Family life was quite until one afternoon, when Shabbir received a telephone call from Faraha's colleague; asking if he knew Faraha's whereabouts. She had not shown up at work in the morning, nor had she called in sick. The colleague was concerned that Faraha might be very upset, because the college president had announced on the previous day that the college would be closing permanently at the end of the academic year. Shabbir was startled by the news, because Faraha had not mentioned it at dinner the evening before. No one heard from Faraha for 3 weeks following the date of her mysterious disappearance. During that time, she traveled to Karachi University with the intention of applying for a position as philosophy professor. One day, she woke up in Karachi hotel room and was mystified about how she had gotten there.*

Dissociative fugue, formerly called psychogenic fugue, a condition in which a person who is confused about personal identity suddenly and unexpectedly travels to another place. The venture may be brief, lasting only hours or days, or it may last for weeks or months. The word fugue comes from the Latin word for "flight."

People in fugue state are unable to recall their own history or identity, and a few may even assume a new identity. During an episode of dissociative fugue, a person may take on a new identity, complete with a new name and even establish a new home and ties to their community. More often, however, the victim realizes something is wrong not long after fleeing—in a matter of hours or days. In such cases, the victim may phone home for help, or come to the attention of police after becoming distressed at finding himself/herself unexplainably in unfamiliar surroundings.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, also known as the DSM-IV-TR lists four criteria for diagnosing dissociative fugue:

- Unexplained and unexpected travel from a person's usual place of living and working along with partial or complete amnesia.
- Uncertainty and confusion about one's identity, or in rare instances, the adoption of a new identity.
- The flight and amnesia that characterize the fugue are not related exclusively to DID, nor is it the result of substance abuse or a physical illness.
- An episode must result in distress or impairment severe enough to interfere with the ability of the patient to function in social, work or home settings.



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Accurate diagnosis typically must wait until the fugue is over and the person has sought help or has been brought to the attention of mental health care providers. The diagnosis can then be made using the patient's history and reconstruction of events that occurred before, during, and after the patient's excursion.

A fugue is rare and usually passes quickly. The disorder is more likely to occur at certain times, such as during a war or following a natural disaster. Personal crises or extreme stress, such as financial problems, the desire to escape punishment (Spiegel & Cardena, 1991) or the experience of a trauma can also precipitate fugue states.

## EXPLANATION FOR AMNESIA & FUGUE

Most experts agree that amnesia and fugue maybe and product of intensely traumatic experiences during childhood, especially those involving abuse (Maldonado, 1998) or other forms of emotional maltreatment (Simon, 2001).

It is very difficult for clinicians to diagnose amnesia because there are so many possible causes of memory loss. It can be caused by a physical dysfunction due to brain injury, substance abuse or epilepsy. Alternatively, other psychological disorders symptoms that may cause the individual to appear amnestic.

A person may fake symptoms to gain certain benefits or advantages. As is true for the issue of repressed memories, there are legal implications in cases reach trial. Juries tend to be skeptical when defendants in criminal cases claim to have dissociative amnesia for the events surrounding their crimes (Porter, & Herve, 2001).

According to the psychoanalytic approach individuals may develop this disorder by repressing unwanted thoughts in their memory, without realizing that they end up developing habit of forgetting things, by repressing even small mishaps in unconscious mind.

A fugue is rare and usually passes quickly. The disorder is more likely to occur at certain times, such as during war or following a natural disaster. Personal crises or extreme stress, such as financial problems and the desire to escape punishments (Spiegal, 1991) or the experience of a trauma (Classon, 1993) can also lead to fugue states.

Many fugues seem to represent disguised wish fulfillment (for example, an escape from overwhelming stresses, such as divorce or financial ruin). Other fugues are related to feelings of rejection or separation, or they may develop as an alternative to suicidal or homicidal impulses.



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# TREATMENT FOR AMNESIA & FUGUE

Psychoanalytic treatment is perhaps more widespread as a choice of treatment for dissociative disorders than for any psychological problems. The goal of lifting repressions is the order of the day, pursued via the use of basic psychoanalytic techniques.

## HYPNOSIS

Ordinarily, the ego's defence mechanisms suppress conscious thoughts. As a result, the bringing of the unconscious into consciousness is not straightforward. Freud and his followers devised several methods to achieve this. Originally, Freud used hypnosis. The state produced by hypnosis seemed to allow his analysands to break through to things of which they were otherwise unaware. However, Freud abandoned hypnosis because afterwards some of his analysands denied the accuracy of what they had revealed during hypnosis, and others found the revelations to be premature and painful.

## DREAM INTERPRETATION

Another method involved the interpretation of the analysand's dreams. Freud believed that the content of dreams is determined by unconscious processes as well as by the 'residue' of the day. The unconscious impulses are expressed in dreams as a form of wish fulfillment. Freud believed dreams to be 'the royal road to the unconscious' and a rich source of information about hidden aspects of personality. For Freud, things that happened during the day evoked repressed childhood memories and desires. However, because some desires are too disturbing for an individual to face, even when asleep, these are expressed in symbolic form.

Freud used the term manifest content to describe the content of the dream as reported by the dreamer and latent content to refer to the dream's presumed hidden or symbolic content. The latent is transformed into the manifest by means of three distorting processes. Displacement refers to the role of symbols in dreams. In a dream, something (such as a king) appears in the manifest dream as a substitute for something else (perhaps the dreamer's father). Concrete representation refers to the expression of an abstract idea in a highly concrete way. The concrete image of a king, for example, could represent the abstract idea of authority, power and/or wealth.

*Typical activities that symbolize sexual intercourse are also climbing and going down the ladder or stairs and running inside a house. The queen and king or empress and emperor and similar relations symbolize parents. The fall into water or rising out of it symbolizes birth.*

Because dissociative disorders are widely believed to arise from traumatic events that the person is trying to block from consciousness, there are links between therapies for these disorders and therapies for posttraumatic stress disorder.



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# ASSIGNMENT

**It is traumatic affect**
It affects 25% of those who experience traumatic events;
It has a dose-effect: the worse the trauma, the worse the distress;
It affects rescuers as well as those being rescued;
It is abnormal affect due to trauma.

(a) Describe what psychologists have learned about abnormal affect due to trauma. [8]

(b) Evaluate what psychologists have learned about abnormal affect due to trauma. [10]

(c) Giving reasons for your answer, suggest how a trauma response could be treated. [6]

** Due on 28th October, 2010



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